UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

MINUTES OF A MEETING OF THE TRUST BOARD, HELD ON THURSDAY 5 NOVEMBER 2015 AT 9AM IN THE C J BOND ROOM, CLINICAL EDUCATION CENTRE, LEICESTER ROYAL INFIRMARY

Voting Members Present:
Mr K Singh – Trust Chairman
Mr J Adler – Chief Executive
Col (Ret'd) I Crowe – Non-Executive Director
Dr S Dauncey – Non-Executive Director
Mr A Furlong – Acting Medical Director
Professor A Goodall – Non-Executive Director
Mr A Johnson – Non-Executive Director
Mr R Mitchell – Chief Operating Officer
Mr R Moore – Non-Executive Director
Ms J Smith – Chief Nurse
Mr M Traynor – Non-Executive Director (from Minute 230/15)
Mr P Traynor – Chief Financial Officer
Ms J Wilson – Non-Executive Director

In attendance:
Ms N Baker – Patient Safety Adviser (for Minute 231/15/2)
Mr M Caple – Patient Partner (for Minute 231/15/2)
Miss M Durbridge – Director of Safety and Risk (for Minute 231/15/2)
Mr D Henson – LLR Healthwatch Representative (up to and including Minute 237/15)
Ms S Johnstone – Ward Sister, Ward 16 Glenfield Hospital (for Minute 231/15/1)
Mr D Kerr – Director of Estates and Facilities (for Minute 241/15)
Ms H Leatham – Assistant Chief Nurse (for Minute 231/15/1)
Dr N Sanganee – LLR CCG representative (up to and including Minute 237/15)
Ms K Shields – Director of Strategy
Mr M Smith – LLR Healthwatch (for Minute 231/15/2)
Ms H Stokes – Senior Trust Administrator
Ms L Tibbert – Director of Workforce and OD
Mr S Ward – Director of Corporate and Legal Affairs
Mr M Wightman – Director of Marketing and Communications
Ms E Wilkes – UHL Reconfiguration Programme Director (for Minutes 231/15/3 and 231/15/4)

ACTION

225/15 APOLOGIES, WELCOME AND INTRODUCTORY REMARKS

There were no apologies for absence. The Trust Chairman opened the meeting by expressing his condolences to the family of Jack Adcock, following the recent Crown Court verdicts in respect of two UHL staff and one agency nurse. Staff in UHL's Children's Services also needed ongoing support from the Trust – although aware that staff were completely committed to providing good quality care, the Chairman nonetheless noted the need for UHL to recognise the pain of Jack Adcock's family.

The Chairman then noted that the Trust Board was signing the Armed Forces Corporate Covenant today at 1.15pm, with Armed Forces representatives and external guests present. In light of this time commitment he requested therefore that authors of papers outline three key points only for their items.

The Chairman welcomed all public attendees to the Trust Board meeting, including the Leicestershire Healthwatch Vice-Chair. He also welcomed Mr A Johnson to his first meeting as a UHL Non-Executive Director (further details on Mr Johnson's background were contained in paper C below).

226/15 DECLARATIONS OF INTERESTS IN THE PUBLIC BUSINESS

No declarations of interest were made.

227/15 MINUTES

Resolved – that the Minutes of the 1 October 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

228/15 MATTERS ARISING FROM THE MINUTES

Paper B detailed the status of previous matters arising and the expected timescales for resolution. Members particularly noted:-

(a) **Minute 207/15 of 1 October 2015** – the Director of Workforce and OD was working with CMGs on the potential use the September 2015 leadership event external speaker for CMG-level events;
(b) **Minute 208/15/1 of 1 October 2015** – development of a positivity and motivation video for staff was being appropriately pursued outside the meeting, between the Director of Marketing and Communications and the Assistant Chief Nurse. The patient featured in the October 2015 Trust Board patient story was keen to be involved, and
(c) **Minute 209/15/2 of 1 October 2015** – the Acting Medical Director had raised the issue of publicising UHL's research profile and performance at a recent EMCRN meeting [which he chaired], and a plan was in place accordingly. The Director of Marketing and Communications also advised that there was a bespoke Communications Lead within UHL's research and innovation function, working to increase visibility of recent achievements. Professor A Goodall, Non-Executive Director noted that the University of Leicester would be keen to assist in this.

Resolved – that the update on outstanding matters arising and any related actions be noted, and progressed by the identified Lead Officer(s).

229/15 CHAIRMAN'S MONTHLY REPORT – NOVEMBER 2015

In introducing his monthly report for November 2015 (paper C), the Trust Chairman particularly highlighted:-

(a) the appointment of Mr A Johnson as a new UHL Non-Executive Director with effect from 1 November 2015;
(b) that Ms J Wilson, Non-Executive Director, Trust Vice-Chair and Chair of the Integrated Finance Performance and Investment Committee, would be stepping down from the Trust Board in December 2015 after 6 years. The Chairman thanked Ms Wilson for her very significant contribution and commitment to the work of UHL. In light of Ms Wilson's departure, the following changes in appointment were proposed in paper C (and now endorsed):- **DCLA**
    - appointment of Mr M Traynor Non-Executive Director (and current Charitable Funds Committee Chair) as IFPIC Chair and Trust Vice-Chair from 1 January 2016;
    - appointment of Col (Ret'd) I Crowe Non-Executive Director as Charitable Funds Committee Chair from 1 April 2016 (to attend as a member of that Committee from now until that date);
(c) his view that a further indepth discussion on workforce issues should be held at a future Trust Board thinking day, and
(d) the need for the Trust to be appropriately aware that it served a diverse, multicultural population and to recognise and embrace the various festivals celebrated by that population, including Ramadan, Diwali and Christmas.

<u>Resolved</u> – that the Committee Chair and Trust Vice-Chair changes detailed in bulletpoint (c) above be endorsed and progressed accordingly. **DCLA**

230/15 CHIEF EXECUTIVE'S MONTHLY REPORT – NOVEMBER 2015

The Chief Executive's November 2015 monthly update followed (by exception) the framework of the Trust's strategic objectives. As the attached quality and performance dashboard covered core issues from the monthly quality and performance report, the full version of that report would no longer be taken at Trust Board meetings but was accessible on the Trust's external website (also hyperlinked within paper D). As requested at the October 2015 Trust Board meeting, the quality and performance dashboard now also included appropriate compliance dates (where applicable). The Chief Executive noted in particular:-

(a) UHL's continued generally-good performance on quality metrics;

(b) that although performance had improved, progress on cancer 62-day waits was moving more slowly than hoped. This target remained challenging nationally;

(c) the continuing difficult situation within ED (covered in further detail within paper J, – Minute 231/15/6 refers). Ambulance handovers remained a critical issue, and winter 2015 was expected to be extremely challenging;

(d) an improvement in the Trust's financial position, as evidenced by the month 6 figures (Minute 232/15/3 below refers);

(e) the disappointing news that national funding had been withdrawn for the Life Study Project, as a result of poor recruitment at the initial London centre. UHL participation had been just about to start, with very good recruitment rates. Discussions were in progress regarding potential alternative use of the facility but these were at an early stage, and

(f) his hope that the EPR business case would receive approval by Christmas 2015, in light of simplified NTDA processes. UHL had reached agreement with IBM regarding alternative funding of the EPR, which had resulted in needing less public capital than originally envisaged. This was a positive development and demonstrated the benefits of being in a longterm partnership such as the one UHL enjoyed with IBM. The Trust Board welcomed this development, given the crucial importance of the EPR project. In discussion, the Chief Financial Officer advised that a summary of the financial arrangements for funding EPR would be presented to the November 2015 IFPIC – the Trust Chairman suggested that a short report on this issue would also be helpful for the Trust Board. **CFO**

In discussion on the report, the Trust Board noted:-

(i) that the November 2015 IFPIC was scheduled to receive a detailed report on ambulance handovers; **CE**

(ii) that the October 2015 IFPIC had received a report on cancer 62-day wait performance. As the IFPIC Chair, Ms J Wilson Non-Executive Director noted the requirement now to report 104-day waiters and requested that this measure therefore be included in the dashboard at paper D. Later in this Trust Board meeting, the Chief Operating Officer explained the rationale for the 104-day measure. In response to a request, the Trust Board agreed to share the recent updated report on cancer 62-day waits performance with the Healthwatch representative, noting also his wish for it to include a date to achieve compliance with this target, and **COO**

(iii) a query from the Healthwatch representative as to when a public update on Interserve FM performance would be available. The Trust Chairman clarified that discussions were currently held in the private session due to commercial and legal issues, and the Chief Executive agreed to share an appropriate update at his next quarterly meeting with Healthwatch (December 2015). **CE**

<u>Resolved</u> – that (A) the new requirement to report cancer 104 day waiters be included in the quality and performance dashboard appended to the Chief Executive's monthly **CE**

report;

(B) the updated cancer action plan (including a date for compliance with the 62-day target) be provided to the Healthwatch representative; **COO**

(C) an update on Interserve issues be provided at the Trust's next quarterly meeting with Healthwatch (2 December 2015), and **CE**

(D) a written briefing on the position re: funding for the EPR project be provided to a future Trust Board. **CFO**

231/15 KEY ISSUES FOR DECISION/DISCUSSION

231/15/1 Patient Story – Creating a Courtyard Retreat

Paper E from the Chief Nurse advised the Trust Board of the positive experience of a family member while their granddaughter was being cared for as an inpatient on the Cystic Fibrosis Unit on ward 16 Glenfield Hospital. The patient's grandmother attended to present the story in person, accompanied by the Assistant Chief Nurse and Ms S Johnstone, Ward 16 Sister. Although her granddaughter had sadly died, the grandmother continued to fundraise for the unit. The patient story advised how funds had been raised to create a courtyard retreat for ward 16, providing a relaxing outside space for patients to enjoy. Paper E outlined how various practical difficulties had been overcome by the dedication of the patient's grandmother and the commitment of the staff. The report also commented on the excellent care that the patient had received during her multiple admissions.

In discussion on the patient story, the Trust Board noted:-

(a) the frustrations experienced by the staff in trying to access charitable funds for this project. In response, the Chief Financial Officer acknowledged the need to review the process and advised that delegated limits had already changed. He emphasised his wish to encourage areas to spend their charitable funds;

(b) Non-Executive Director comments welcoming the very significant improvements to the ward 16 courtyard space. Given the very positive therapeutic impact that garden spaces had for patients, Professor A Goodall, Non-Executive Director requested that UHL review the frequency with which such spaces were maintained; **DEF**

(c) the Chief Executive's intention to contact UHL's Head of Fundraising re: a potential Trust-wide approach to charitable funding towards outside spaces to benefit both patients and staff; **CE**

(d) that the Director of Strategy would ensure that the Reconfiguration Board took appropriate account of outside spaces and landscaping, and **DS**

(e) a request from the patient's grandmother to review the television provision on ward 16. In response, the Chief Executive undertook to check progress on the plans to provide free wif-fi across the Trust, which had been piloted on the LRI Children's wards. **CE**

Resolved – that (A) the (adequacy of the) frequency of maintenance of UHL's garden spaces be reviewed; **DEF**

(B) the Reconfiguration Board be requested to take appropriate account of outside space and landscaping requirements; **DS**

(C) the progress towards provision of free wif-fi on Children's wards be clarified, and **CE**

(D) the Trust's Head of Fundraising be contacted re: a potential Trust-wide approach for creating outside spaces to benefit patients and staff. **CE**

231/15/2 Independent Complaints Review Panel (ICRP) Presentation

Paper F from the Acting Medical Director advised the Trust Board of the work of the Independent Complaints Review Panel established by UHL following a 2014 complaints public engagement event. The purpose of the Panel was to review a sample of complaints from the patient perspective, and report back to UHL's Patient Information and Liaison Service on what had been handled well/not so well. An anonymous summary report was then provided by the Panel to the Director of Safety and Risk every quarter, highlighting common themes and trends from the complaints reviewed.

In addition to Miss M Durbridge Director of Safety and Risk and Ms N Baker Patient Safety Adviser, Mr M Smith Healthwatch and Mr M Caple Patient Partner attended for this item. POhWER were also members of the ICRP but could not be present today. Paper F detailed the views of each of those independent organisations upon UHL's complaints handling process, and all commented on the open and positive nature of their relationship with the Trust. Other comments related to the fact that UHL complaint responses could still be too full of medical jargon and contained a lengthy chronology which was not always helpful; the need to consider a meeting more often in order to resolve the complaint, and also the fact that the Trust occasionally apologised too much in its responses. However, it was noted that UHL now held 3 times more face-to-face contacts than two years earlier. The ICRP members also noted that they were happy with their decision not to contact individual complainants after the Panel had reviewed the Trust's response. In discussion on the work of the ICRP, the Trust Board:-

(a) noted the Patient Safety Team's plans for 2016 including community complaint clinics, a concerns engagement event with GPs, and further work with a psychologist to improve the quality of UHL's apologies in complaints letters;

(b) emphasised the need to focus on the quality of responses rather than on timeliness only, and to humanise the process appropriately;

(c) queried the process for rolling out the ICRP recommendations – in response, it was noted that these were being fed back to the CMG complaints leads and to UHL's central complaints team. In discussion, the Acting Medical Director requested that the ICRP also be invited to feeback in person to the CMG clinical leadership teams. A complaints learning e-module would also be available on the new safety learning portal. **AMD/ DSR** The Non-Executive Director Chairs of QAC and IFPIC asked that an update on UHL's complaints process and themes (including the work of the ICRP as appropriate) be provided to both a future QAC meeting and to the attendees from the original 2014 complaints engagement event; **AMD**

(d) recognised that Mr M Smith, Healthwatch, had been instrumental in progressing the ICRP, and commented that this was reflective of the very good relationship between Healthwatch and the Trust. The Director of Marketing and Communications asked if Healthwatch representatives might consider how best to publicise their good engagement work with UHL, to the wider public; **HW**

(e) queried how the Trust gauged whether complainants were happy with their complaint responses. The Director of Safety and Risk advised that the complaints team did used to seek feedback from complainants, but response rates had been very low. The emphasis was now on personal contact from the outset to resolve complaints. Mr M Smith, Healthwatch, commented that (anecdotally) UHL was better than its peers in terms of complaint responses;

(f) queried what training was available for staff in writing complaint responses. In response,

the Trust Board was advised that the complaints team (PILS) had been significantly upskilled, with a checklist also available for letters. In further discussion, the Trust Chairman suggested a potential need to restructure the letters in order to avoid lengthy chronologies and make the actual outcome more apparent to the complainant in a shorter document. The Trust Chairman also reiterated his intention to try and invite the Parliamentary Health Service Ombudsman to visit UHL, potentially to meet with the ICRP organisations as well as UHL staff.

Resolved – that (A) the ICRP be invited to provide feedback on complaints themes to the CMG clinical leadership teams; **AMD/ DSR**

(B) a further update on UHL's complaints process and themes (including the work of the ICRP as appropriate) to be provided to:-
(1) the attendees at the June 2014 complaints engagement event and
(2) QAC, and **AMD/ DSR**

(C) Healthwatch representatives be invited to consider how best to publicise their good engagement work with UHL, to the wider public. **HW**

231/15/3 East Midlands Congenital Heart Centre (EMCHC)/Congenital Heart Review – Update

Paper G from the Director of Strategy updated the Trust Board on UHL's proposals to establish a Midlands Congenital Heart Network and on progress towards meeting the standards and service specification from the New Congenital Cardiac Review. The measures planned to meet those standards included (i) increasing surgical numbers; (ii) putting in place a retrieval service for critically-ill children and (iii) moving children's congenital heart services to the Children's Hospital at the LRI. In discussion on the update at paper G, the Trust Board:-

(a) noted (in response to a Non-Executive Director query) that UHL would have to be part of the national strategy in order to continue providing children's congenital cardiac surgery;

(b) noted UHL's partnership arrangements with Northamptonshire GPs and CCGs, the Trust's developing relationship with Northamptonshire Cardiologists and preliminary discussions with Coventry and Warwickshire;

(c) queried the implications of the competitive tendering process, if UHL's proposals were not accepted. In response it was advised that the steps in paper G would also stand UHL in good stead in the event of a competitive tendering process;

(d) queried whether Bristol was still involved in the Network proposals, as originally. The Director of Strategy advised that Bristol was now in a network situation with Wales and had thus withdrawn from the proposals in paper G. In response to a further query, the Director of Strategy considered that the UHL-Birmingham relationship was stable, although she accepted that further formalisation of financial and governance arrangements would be needed if the Network progressed;

(e) noted (in response to a query) that there was a derogation period from 1 April 2016 in respect of the 350 cases needed. The Director of Strategy considered, however, that the longterm target of 500 cases by 2020 would be challenging for UHL;

(f) requested that an appropriate briefing on paper G be provided to both internal and external stakeholders. The need to share information more widely was supported by the Healthwatch representative, and the Director of Marketing and Communications agreed to discuss this at the next Children's Project Board meeting, and **DMC**

(g) outlined the nature of UHL's existing children's cardiac services, for the benefit of the

new Non-Executive Director, confirming that a Children's Hospital including children's heart services was a key service priority for the Trust.

Resolved – that the issue of how best to update internal and external stakeholders on UHL's plans re: the congenital heart service review, be raised at the next Children's Project Board meeting. **DMC**

231/15/4 Strategy Update – UHL Reconfiguration Programme

This monthly update from the Director of Strategy updated the Trust Board on (i) the governance of UHL's reconfiguration programme; (ii) progress on 1-2 selected workstreams, and (iii) the 3 key programme risks, while the high-level dashboard appended to the report provided an overview of the programme status and key risks as a whole. In terms of key workstream deep dives, paper H focused on Estates. In introducing the report, Ms E Wilkes Reconfiguration Programme Director advised that the project was now moving into the key operational phase, and noted that the dashboard RAGs were primarily amber. In discussion on the monthly update the Trust Board:-

(a) agreed to the suggestion that the December 2015 monthly Trust Board update focus on the workforce workstream. A dedicated workforce workstream lead was now in place and OD elements were also now on the reconfiguration risk register; **DS**

(b) noted that the first tranche of ICS (Intensive Community Support) beds had opened in October 2015 as part of the out of hospital workstream;

(c) noted progress on the Estates workstream, including the establishment of an LGH planning group. A 'specialty destination matrix' was also in development to assess which services would remain on the LGH site and what business cases were required. The state of UHL's entire estate was also being validated, together with a whole-site assessment of the non-clinical and commercial space available;

(d) noted that an overarching project plan across all workstreams was in development – this would be presented to the November 2015 Trust Board thinking day and potentially also to the December 2015 Trust Board; **DS**

(e) queried the impact on operational services, further detail on which would be presented as part of the 12 November 2015 Trust Board thinking day on reconfiguration. The Chief Operating Officer noted the need for a range of appropriate contingency plans also to be developed;

(f) queried whether LPT were still experiencing challenges in recruiting staff (re: the out of hospital workstream). This was still a challenge, compounded by the new national requirement for a cap on agency nurse staffing spend. The Chief Nurse and the Director of Workforce and OD were working closely with their LPT counterparts re: workforce issues, to ensure that the two organisations were not trying to recruit the same staff, and secondments were in place to facilitate the first phase of the left shift process. In response to a query by the IFPIC Non-Executive Director Chair, the Trust Chairman agreed to raise the issue of the agency nurse staffing spending caps at the next LLR Chairs' meeting; **CHAIR MAN**

(g) noted a query from Professor A Goodall Non-Executive Director as to whether UHL work on embedded space was appropriately aligned to similar work by the University of Leicester. It was confirmed in response that joint UHL-UoL work on assessing the embedded space was nearing completion, and the Reconfiguration Project Director agreed to brief Professor Goodall outside the meeting on the various discussions taking place. The Chief Executive commented that the second part of this work needed to focus on the implications for reconfiguration; **DS/ RPD**

(h) noted the need to ensure that education and training input was appropriately integrated into reconfiguration discussions. Although UHL's education and training lead had been invited to sit on the Reconfiguration Board the Chief Executive considered that a more in-depth interface was needed, and he asked the Director of Strategy to explore this accordingly. It was further noted that an education and training facilities strategy was being presented to the November 2015 Executive Strategy Board; **DS**

(i) requested that future monthly updates clarify the "% complete" indicator used on the dashboard (eg whether this was the % against the overall workstream or the % against expected progress to date); **DS/ RPD**

(j) agreed that future iterations of the Trust Board report on UHL reconfiguration should also include information on:-

- risks (and related scenario planning) to the reconfiguration programme;
- the interdependencies of the various elements and their consequences;

(g) requested that the risks to the project be covered at the November 2015 Trust Board thinking day, as the project currently felt more risky than presented in paper H, and

(h) noted the Healthwatch representative's wish to receive assurance that those organisations impacted by reconfiguration were appropriately sighted to the various changes and planned mitigating actions.

<u>Resolved</u> – that (A) the workforce workstream be reviewed in detail at the December 2015 Trust Board; **DS**

(B) the following issues be discussed at the 12 November 2015 Trust Board thinking day:- **DS**
(1) overarching reconfiguration workstream project plan (this also potentially to be considered at the December 2015 Trust Board;
(2) the risks facing the programme;

(C) the issue of the national cap on agency nurse spending be discussed at the next LLR Chairs' meeting; **CHAIR MAN**

(D) the UHL Reconfiguration Programme Director be requested to clarify the discussions with the University of Leicester re: embedded space, to Professor A Goodall Non-Executive Director outside the meeting, and **DS/ RPD**

(E) further thought be given to how best to include education and training representatives within the reconfiguration programme (beyond membership of the Reconfiguration Board). **DS**

231/15/5 <u>LLR Better Care Together (BCT) Programme Update</u>

Paper I provided a high-level update on the LLR Better Care Together Programme, as prepared for all partner organisations' Boards (accompanied here by an internal UHL covering report). Work continued with the BCT project management office on the development of a BCT dashboard.

As noted in Minute 231/15/4 above, the first phase of the out of hospital project (ICS beds) had now begun, and the Director of Strategy suggested undertaking an appropriate 'lessons learned' exercise in early 2016. The Director of Strategy also noted that the East Midlands Clinical Senate's peer review of BCT plans had been received in October 2015 – although supportive of the overall direction of travel this report had contained some recommendations for further work as detailed in paper I. **DS**

In discussion on paper I, the Trust Board:-

(a) was advised by the Chief Executive of likely slippage on the BCT public consultation launch, in light of NHS England comments on the pre-consultation business case. Although NHSE remained supportive, the consultation was likely to be delayed by 2-3 months and an update on this issue would therefore be provided to the December 2015 Trust Board. The Trust Chairman requested that this update also cover any risks to/implications for UHL's reconfiguration programme from that delay; **DS**

(b) sought assurance on whether sufficient progress was being made on the two key risks to the BCT programme (workforce and organisational culture). The Director of Strategy advised that previously-unknown issues were emerging re: the organisational culture risk, which was currently red RAG-rated due to the absence of a mitigation plan. The reason for the red RAG rating for the workforce risk had changed since May 2015 and included new issues such as the impact of the national cap on agency spending. The Director of Strategy recognised, however, that it would be useful for future reports to include an explanatory narrative on these risks, and **DS**

(c) noted comments from the Trust Chairman on the need to make progress on developing a BCT dashboard.

<u>Resolved</u> – that (A) a 'lessons learned' exercise re: the Intensive Community Support Service beds be undertaken at an appropriate point in early 2016; **DS**

(B) a further update on the implications of any BCT slippage (including risks to UHL's reconfiguration programme) be provided to the 3 December 2015 Trust Board, and **DS**

(C) future BCT updates include an explanatory narrative for the 'top 2 risks and issues' section. **DS**

231/15/6 <u>Emergency Care Performance and Winter Contingency Plan</u>

Further to Minute 208/15/4 of 1 October 2015, paper J from the Chief Operating Officer updated the Trust Board on recent emergency care performance, which stood at 91.3% for the year to date despite continued atypically-high attendance and admission rates. The Chief Operating Officer advised that – organisationally – winter 2015 had now begun, and he noted that performance in the last 2 weeks had been worse than in January 2015, with average daily attendance levels of 651 patients and a peak level of 713 patients on one day, which was beginning to impact on on-the-day cancellations. Discharge levels for emergency patients had risen in October 2015, however, which was welcomed.

The Chief Operating Officer reiterated the crucial need to address attendance and admission levels and advised that management of the Urgent Care Centre had now transferred to UHL from George Eliot Hospital (31 October 2015) – the new ED front door arrangements had also begun on 3 November 2015 (use of GPs with a specialist interest in emergency medicine). In discussion on emergency care performance and winter pressures the Trust Board:-

(a) noted the actions being taken both by UHL and the Community, as detailed in paper J – in addition to the new UCC and ED front door arrangements Leicester City CCG had opened up an additional 1700 GP slots per week across 4 GP hubs, the winter communications campaign had begun, and actions had been agreed to improve the day-to-day flow across the LLR healthcare system. A Board to Board meeting involving UHL, LPT and CCGs had also taken place on 8 October 2015, at which emergency pressures had been discussed in detail;

(b) noted a crisis escalation meeting held on 4 November 2015 involving the NTDA, EM

Ambulance Service and UHL re: ambulance handover issues, with steps now put in place to expand Trust outflow capacity (Unipart initiative with EMAS). The Trust Board noted that the CQC was likely to visit the LRI as part of its imminent inspection of EMAS;

(c) noted the detailed information now tabled by the Chief Operating Officer re: ED attendances and admissions, and key actions relating to inflow, general flow [UHL-specific actions], outflow, and systems management/design. The Chief Executive commented on the very significant (and still growing) gap between historic admission/attendance levels and the 2015 trend – he also noted that the current demand management actions appeared insufficient to mitigate current demand; the Trust Board therefore needed to consider what other steps were needed;

(d) queried whether any further benefit was likely to be gained from the current inflow actions. Although recognising that there was a lead-in time for certain actions, the Chief Operating Officer considered that the most which could realistically be hoped for was that the actions would neutralise any further demand increases;

(e) noted that LLR was atypical in terms of the ambulance handover times issue;

(f) noted a query from the CCG representative on whether the reasons for the variation in CCG demand levels were known. Dr Sanganee also queried whether the Leicester City approach (extra GP slots) had been shared with other two Leicester(shire) CCGs. In response, the Chief Operating Officer considered that the CCG activity variation was geographically-based, with the Leicester City CCG activity increase linked largely to deprivation issues. With regard to the additional GP slots, Leicester City had funded these from the Prime Minister's Challenge Fund so those monies would not therefore be available to ELR and West Leicester CCG;

(g) noted comments from the CCG representative on the poor GP recruitment levels within the East Midlands. Professor A Goodall Non-Executive Director noted that the University of Leicester was meeting with CCGs to discuss ways of recruiting to primary care, although acknowledging that this would not help this winter;

(h) voiced concern over the lack of assurance from the current demand management initiatives, and suggested that it might be timely to revisit the 2014 emergency care system work done by Professor I Sturgess. The Trust Chairman welcomed this suggestion and requested an appropriate 1-page briefing accordingly, for discussion at the next LLR Chairs' meeting. The Chief Executive also agreed to discuss specific inflow issues with Mr T Sanders, Managing Director of West Leicester CCG, and **COO** **CE**

(i) noted a query from the Director of Strategy as to whether lessons from West Leicestershire CCG's reduction in demand could be applicable to the other CCGs – it was agreed to explore this further, although noting comments from the CCG representative that it probably reflected WL CCG's use of other providers. The Director of Strategy also suggested asking Leicester(shire) Local Authorities to review local population demographics, to assess potential reasons for any rise in acuity. **DS/ COO** **DS/ COO**

<u>Resolved</u> – that (A) a brief 1-page report on the actions taken to address inflow issues (eg LLR system response to previous Ian Sturgess recommendations) be produced for discussion at the next LLR Chairs' meeting; **COO**

(B) progress on inflow actions be raised with the Managing Director, West Leicester CCG; **CE**

(C) Leicester(shire) Local Authorities be requested to consider undertaking a review of the local population demographic, to assess the reasons for any increase in acuity, and **DS/ COO**

(C) information be sought on the reasons for WL CCG's reduced inflow to UHL and whether any steps taken could be extended to other CCGs. **DS/ COO**

231/15/7 UHL Risk Report incorporating the Board Assurance Framework (BAF)

Paper K from the Acting Medical Director comprised the latest iteration of the 2015-16 Board Assurance Framework (as at 30 September 2015) and a summary of all high and extreme risks on the risk register. Three new high risks had been opened in September 2015 (relating to [i] risk to the quality of patient cardiac rehabilitation individual assessments due to a new LRI clinic location; [ii] the potential risk of the transplant laboratory's IT database crashing, and [iii] the risk of the Transplant Laboratory not receiving CPA accreditation). Col (Ret'd) I Crowe Non-Executive Director requested further assurance on the mechanisms for backing up the Trust's IT systems in the event of a crash, and it was agreed that the Chief Information Officer would advise the Executive Information Management Board (cc: Non-Executive Directors). **CE/CIO**

In general discussion on the BAF report, the Chief Operating Officer queried whether Interserve FM issues needed to be added as new principal risk. The Trust Chairman also queried whether the current nature of the ED and reconfiguration principal risks was appropriately reflected – Ms J Wilson, IFPIC Non-Executive Director Chair queried whether the reconfiguration principal risk was appropriately covered by the reconfiguration update earlier on the agenda, noting its risk rating of 20. Mr A Johnson Non-Executive Director queried how the principal risks were prioritised, as this was not immediately obvious from the report itself – in response, the Director of Strategy commented that this would be discussed further at the November 2015 Trust Board thinking day and members noted ongoing discussion re: the format of UHL's BAF. **EDs/ AMD**

In terms of the specific risks being discussed at this meeting the Trust Board noted:-

(a) **principal risks 16 and 17** – the Chief Financial Officer was broadly happy with the current risks scores (15 in both cases), and advised that alternative sources of capital were being explored by UHL including from its private sector partners and access to non-Treasury finance. The Chief Financial Officer considered that sign-off for UHL's longterm financial model was unlikely at this stage given the changing national NHS financial context and the focus on current-year capital requirements. The Trust Chairman suggested that the November 2015 Trust Board thinking day on reconfiguration could also discuss this wider national financial context, and

(b) **principal risk 15** – there were no comments on this risk (current risk score of 9).

Resolved – that (A) assurance be sought from the Chief Information Officer re: the effective back-up of UHL IT systems in the event of any systems 'crash', and circulated to the Executive IM&T Board and Non-Executive Directors accordingly, and **CE/ CIO**

(B) consideration be given to whether the risks facing the Emergency Department and the Reconfiguration Programme are appropriately reflected in the BAF (and to give further consideration of a potential principal risk re: facilities management issues). **EDs/ AMD**

231/15/8 Appointment of UHL Interim Responsible Officer

Paper L from the Acting Medical Director sought Trust Board approval to appoint Professor P Furness as UHL's Interim Responsible Officer from 16 November 2015 (following the departure of the current Responsible Officer) to 31 March 2016. The Trust Board noted the statutory requirement to have a Responsible Officer and endorsed the proposed appointment. **AMD**

Resolved – that Professor P Furness be appointed as UHL's Interim Responsible Officer from 16 November 2015 – 31 March 2016. **AMD**

232/15 QUALITY AND PERFORMANCE

232/15/1 Quality Assurance Committee (QAC)

Resolved – that the summary of key issues considered at the 29 October 2015 QAC meeting be received and noted (no specific recommendations for Trust Board approval) – paper M.

232/15/2 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the summary of key issues considered at the 29 October 2015 IFPIC meeting be received and noted (no specific recommendations for Trust Board approval) – paper N.

232/15/3 2015-16 Financial Position – Month 6 (September 2015)

Further to Minute 211/15/4 of 1 October 2015, paper O provided an integrated report on month 6 financial performance (month ending 30 September 2015) and delivery of the revised 2015-16 financial plan. As per its revised financial plan submitted to the NTDA on 11 September 2015, UHL was now planning for a deficit of £34.1m in 2015-16, including delivery of a £43m cost improvement programme. As at 30 September 2015, UHL financial performance was £0.5m adverse to plan, resulting primarily from income over-performance of £0.5m offset by a pay overspend of £0.5m and a non-pay overspend of £0.5m. Capital spend was £16.4m compared to a plan of £30m and UHL's month 6 cash balance stood at £5.2m (£2.2m above the planned level). The Chief Financial Officer commented on the increasing difficulty of accessing public sector capital, particularly in the run-up to the publication of the Comprehensive Spending Review (eg Emergency Floor project still awaiting formal Department of Health approval).

The Chief Financial Officer recognised that appropriate messaging of the financial position was crucial, given that the numbers had changed reflecting the revised financial plan and control total. He agreed to include an appropriate explanatory narrative in future reports, to reflect this change, and it was noted that the financial position was also communicated to staff through the Chief Executive's monthly briefings. Even against the original plan, however, month 6 performance had improved due mostly to pay issues. Recovery plans were now in place with 5 of UHL's 7 Clinical Management Groups, with agreement on the remaining 2 due imminently. **CFO**

In discussion, the Chief Operating Officer noted the crucial need to maintain the month 6 improvement and commented on an emerging risk (as a result of emergency pressures) to the Trust's ability to generate income through elective activity. Mr R Moore, Audit Committee Non-Executive Director Chair, queried whether the Emergency Floor project was at serious risk – in response, the Chief Financial Officer provided assurance that the project was being closely monitored internally, although acknowledging that there were some risks while formal sign-off was not yet in place. He advised that the project was approaching a point where contractors would require significant financial commitments – the NTDA was aware of this situation and remained supportive of the existing project timeline. In response to a further query from the Audit Committee Non-Executive Director Chair, the Chief Financial Officer advised that he would likely become significantly concerned if the project was not approved by the end of November 2015. UHL's Emergency Floor was not considered to be a controversial project nationally, however.

Mr D Henson, Healthwatch representative, noted his assurance on both the Trust's financial position at month 6 and the level of local CMG ownership and control. He hoped that this would avoid any future financial 'surprises', although he noted the Chief Operating Officer's comments that issues impacting on CMGs' finances were not always within their control.

Resolved – that the financial performance report's narrative be reviewed, to ensure that future iterations appropriately explained the position due to the change in control total. **CFO**

233/15 REPORTS FROM BOARD COMMITTEES

233/15/1 Audit Committee

Resolved – that the 17 September 2015 Audit Committee Minutes be received and noted, and the recommendations therein be endorsed (recommended items as approved by the Trust Board on 1 October 2015).

233/15/2 Quality Assurance Committee (QAC)

Resolved – that the 24 September 2015 QAC Minutes be received and noted, and the recommendations therein be endorsed, taking particular note of the presentation of the report from the 2014 LSA visit.

233/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that the 24 September 2015 IFPIC Minutes be received and noted and the recommendations therein be endorsed.

234/15 CORPORATE TRUSTEE BUSINESS

234/15/1 Charitable Funds Committee

The Minutes of the 1 October 2015 Charitable Funds Committee (paper S) presented a number of items for Trust Board approval as Corporate Trustee, including revised terms of reference for the Charitable Funds Committee (Minute 42/15 – terms of reference also appended to paper S), charitable funds applications (Minute 43/15), and the Leicester Hospitals Charity Annual Report 2014-15 (Minute 44/15).

Resolved – that the Minutes of the 1 October 2015 Charitable Funds Committee be received, and the recommendations and decisions therein be endorsed and noted respectively by the Trust Board as Corporate Trustee. **DCLA**

235/15 TRUST BOARD BULLETIN – NOVEMBER 2015

Resolved – that the Trust Board Bulletin containing the following report be noted:- (1) NHS Trust Over-Sight Self Certification return for the period ended 31 August 2015 [noting the continuing cleanliness concerns expressed by the Trust] (paper 1).

236/15 QUESTIONS AND COMMENTS FROM THE PRESS AND PUBLIC RELATING TO BUSINESS TRANSACTED AT THIS MEETING

There were no questions/concerns/comments raised by public attendees in respect of the subjects discussed at the meeting.

237/15 EXCLUSION OF THE PRESS AND PUBLIC

Resolved – that, pursuant to the Public Bodies (Admission to Meetings) Act 1960, the press and members of the public be excluded during consideration of the following items of business (Minutes 238/15 – 247/15), having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

238/15 DECLARATIONS OF INTERESTS IN THE CONFIDENTIAL BUSINESS

No declarations of interest were made in respect of the confidential business.

239/15 CONFIDENTIAL MINUTES

Resolved – that the confidential Minutes of the 1 October 2015 Trust Board be confirmed as a correct record and signed by the Trust Chairman accordingly. **CHAIR MAN**

240/15 CONFIDENTIAL MATTERS ARISING REPORT

Resolved – that the confidential matters arising log be received and noted.

241/15 REPORT FROM THE DIRECTOR OF ESTATES

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

242/15 REPORT FROM THE DIRECTOR OF STRATEGY

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

243/15 REPORT FROM THE ACTING MEDICAL DIRECTOR

Resolved – that this Minute be classed as confidential and taken in private accordingly, on the grounds of personal data.

244/15 CORPORATE TRUSTEE BUSINESS

244/15/1 Charitable Funds Committee

Resolved – that this item be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

245/15 REPORTS FROM BOARD COMMITTEES

245/15/1 Audit Committee

Resolved – that the confidential Minutes of the 17 September 2015 Audit Committee be received and noted, and the recommendations therein be endorsed.

245/15/2 Quality Assurance Committee (QAC)

Resolved – that this item be classed as confidential and taken in private accordingly, on the grounds that public consideration at this stage could be prejudicial to the effective conduct of public affairs.

245/15/3 Integrated Finance, Performance and Investment Committee (IFPIC)

Resolved – that this item be classed as confidential and taken in private accordingly, on the grounds of commercial interests.

245/15/4 Remuneration Committee

Resolved – that the confidential Minutes of the 1 October 2015 Remuneration Committee be received and noted, and the recommendations therein be endorsed.

246/15 ANY OTHER BUSINESS

246/15/1 Report from the Director of Workforce and OD – Potential Junior Doctors' Industrial Action

The Director of Workforce and OD advised members that 526 junior doctors within UHL would be eligible to vote in the forthcoming junior doctors' ballot on industrial action. The earliest date that any resulting industrial action could occur would be 25 November 2015, and UHL had begun appropriate planning accordingly. The Director of Workforce and OD also noted that updated proposals were being presented to junior doctors by the Secretary of State for Health.

Resolved – that the position be noted.

247/15 DATE OF NEXT TRUST BOARD MEETING

Resolved – that the next Trust Board meeting be held on Thursday 3 December 2015 from 9am in Seminar Rooms 2 & 3, Clinical Education Centre, Glenfield Hospital.

The meeting closed at 1.05pm

Helen Stokes – **Senior Trust Administrator**

Cumulative Record of Attendance (2015-16 to date):
Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
K Singh	8	8	100	R Mitchell	8	8	100
J Adler	8	8	100	R Moore	8	8	100
I Crowe	8	8	100	C Ribbins	4	3	75
S Dauncey	8	6	75	J Smith	4	4	100
A Furlong	8	8	100	M Traynor	8	7	88
A Goodall	6	5	83	P Traynor	8	8	100
A Johnson	1	1	100	J Wilson	8	8	100

Non-Voting Members:

Name	Possible	Actual	% attendance	Name	Possible	Actual	% attendance
D Henson	8	8	100	E Stevens	4	4	100
R Palin	5	3	60	L Tibbert	4	4	100
N Sanganee	2	2	100	S Ward	8	8	100
K Shields	8	6	75	M Wightman	8	8	100